bleeding acute gastroduodenal mucosal ulcerations. No one operation will suffice for all circumstances and the proper selection will depend primarily upon the patient in relation to his general condition, predisposing causes, and the operative findings. There is less uncertainty with regard to management when stress ulceration is complicated by perforation. Prompt operation with simple closure and omental reinforcement with or without vagotomy and pyloroplasty are indicated. When huge perforations are present, gastric resection becomes necessary.

At present, "stress-ulceration" is a nondescript term referring to acute gastroduodenal mucosal ulceration in a heterogeneous group of patients. For this reason treatment, too, must be highly individualized.

EARL F. WOLFMAN, JR., M.D.
Professor and Chairman
Department of Surgery
School of Medicine
University of California, Davis

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National Education Week on Smoking

THE NATIONAL and California Interagency Councils on Smoking and Health have designated January 9 through 15, 1972 as National Education Week on Smoking. As a component member of The Interagency Council, the CMA has a special responsibility to participate in this week-long effort to further publicize and emphasize the health hazards of smoking.

There should be no further need to detail for physicians the latest findings linking smoking and disease. Since the historic first report in 1964, the Surgeon General has issued four supplemental reports further corroborating and extending the original conclusions. Encouraging statements of commitment and exhortation have issued from the World Health Organization and the AMA; our own CMA at its 1971 meeting passed resolutions declaring opposition to smoking in all public places and in CMA sessions, and urging the elimination of cigarette advertising from all media. Meanwhile the ban on TV and radio cigarette advertising took effect on January 2, 1971, presumably heralding a new era of public and governmental activism in the campaign to educate and thereby protect the citizenry against what many authorities consider our worst public health hazard.

Despite these encouraging portents, accompanied by indications that many millions have indeed given up smoking, we must acknowledge that many other millions have meantime become newly addicted and re-addicted to smoking. Smoking incidence remains disturbingly high among the poor and uneducated, has fallen off relatively little in women, and is actually rising among teen-agers. Concurrently the indomitable cigarette industry inexorably grinds out new and ingenious advertising approaches which effectively vitiate the fading impact of the TV and radio ban and the Surgeon General's reports.

In this context, what is the physician's responsibility? Beyond repeatedly urging our patients to cease smoking (advice which is still unfortunately neither given nor much less heeded consistently) surely there are other avenues to be taken, some quite close to home, and other more adventurous routes to physician involvement in community and political activity. Certainly at the local level, the surface has barely been scratched. How many County Medical Societies have seriously tried to influence the public smoking activities of their members? Is it surprising if many smokers (and especially children and teen-agers) are cynical and skeptical about our warnings, when physicians puff in public, when profitable cigarette machines remain virtually unassailable in hospitals and other health facilities? These are obvious areas for physician leadership. There are some other directions: physicians might more actively petition and pressure their legislative representatives at local, state and national levels for more effective curbs on advertising, more protection for the rights of non-smokers, and elimination of subsidies for tobacco growers. Many physicians are conscientiously engaged in such activities; many more are needed in order to demonstrate, convincingly, our professional commitment and implement our knowledge and convictions about the unconscionable damage to the public health from smoking.

JACK LEIBMAN, M.D.
Chairman, San Francisco Interagency Council on Smoking and Health